Chapter Five

Group identification and addictive health behaviours in adolescents

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"Good habits formed at youth make all the difference" (Aristotle)

Adolescents are an important population to investigate when considering the nature and origins of addiction. Adolescence is a time when many risky health behaviours begin, with drugs, smoking, and alcohol use increasing dramatically during this period (Nielsen, Ringgaard, Broholm, Sindballe, & Olsen, 2002). Consistent with Aristotle's words, such behaviours have a strong tendency to persist into adult life (Degenhardt et al., 2008).

Individuals who abuse substances throughout their life are damaging to society, to the economy, and to their own health. Within Scotland, smoking is still the primary preventable cause of ill health and premature death (NHS National Services Scotland, 2014), being responsible for around 13,000 deaths each year, and many more hospital admissions (Scottish Government, 2008a). Excessive drinking increases the risk of lasting health damage, with alcohol-related mortality more than doubling in the last 15 years and alcohol use being responsible for 40,000 hospital discharges per year (Scottish Government, 2009). Excessive alcohol use also has social consequences, (e.g., family breakdown, crime, disorder, and sickness-related absence from work), which cost the economy an estimated £2.25 billion every year (Scottish Government, 2009). In addition to this, Scotland has a long-standing and serious drug problem, with an estimated 52,000 drug users presenting an economic and social cost of £2.6 billion per annum. Whilst these figures refer to the consequences of Scots using a variety of substances, cannabis is the most commonly used illegal drug in Scotland, with 1 in 3 citizens using cannabis at some point in their lives, and 1 in 10 doing so in

the past year (Scottish Government, 2008b). With these costs in mind, it makes sense to examine issues around adolescent addiction and health-related behaviour, and explore how we might encourage adolescents to form the life-long 'good habits' of which Aristotle spoke.

Research indicates that adolescents are particularly prone to engaging in negative health behaviours for several reasons, some of which relate to individualistic factors, and some of which relate to socially-determined factors (e.g., group memberships). While interest in the latter is growing, there has been a lack of theoretically-based perspectives from which to address such issues. This chapter considers how the social identity approach to group psychology (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) can offer a solution. Building upon previous research which focuses on social factors, the social identity approach suggests that group *identification* (rather than group contact) has implications for health behaviour. Identity processes are then considered in relation to recent research in treatment settings, and suggestions for prevention are discussed. The chapter concludes by suggesting that the social identity approach provides an informative and nuanced perspective from which to address addictive behaviours in adolescence and adulthood.

Examining adolescent addictive behaviours in social terms

It is important to bear in mind that adolescence is a time of transition, often coinciding with loss and change of social groups (e.g., school, friends, and peers). This has implications not only for an individual's social world, but also for their identity and sense of self. In societies where children finish primary/elementary school and begin secondary/high school, this transition usually occurs during the early period of

adolescence (around 11 or 12), and generally involves moving from one school to another, with the resulting change of location, staff, and peers. This potentially entails the loss of several core identities, which can have a variety of negative consequences (Breakwell, 1986; Chandler & Proulx, 2008; Hopkins & Reicher, 1997; Thoits, 1983). There can also be resistance to identification with the new group/s if old identities cannot be relinquished or reconciled so that they fit into the new context (Ellemers, 2003; Haslam, Eggins, & Reynolds, 2003). This can lead to feelings of isolation, confusion, and uncertainty.

This uncertainty can be confounded by adolescents' tendencies to distance themselves from the childhood identities linked to their immediate families (Seidman & French, 2004). The opinions and values of parents/caregivers become less important at this time, and the influence of such individuals declines. As this happens, the influence of friends usually becomes stronger (Collins & Steinberg., 2006; Viner et al., 2012), with adolescents perceiving peer validation as increasingly important (Hogg, Siegel, & Hohman, 2011). Feeling that one 'belongs' and 'fits in' is particularly important at this time, as is feeling valued, liked, and accepted by peers (Coleman, 1974; Erikson, 1968; Newman & Newman, 2001). Unfortunately, attempts to achieve these goals can encourage adolescents to engage in risky behaviour. Indeed, it has been shown that alcohol and cigarette use are frequently used as a method to display commitment to a peer group and to gain the group members' approval (Dolcini & Adler, 1994; Luther & McMahon, 1996). Drug use may also be used as a way to promote one's social standing (Luthar & D'Avanzo, 1999), with socially active and socially attractive adolescents more likely to use drugs (Selnow & Crano, 1986) and initiate marijuana use at an early age (Smith & Fogg, 1978). Siegel, Alvaro, Patel and Crano (2009)

found that adolescents believed that using inhalants increased their popularity with peers, and those who reported greater substance use experienced higher ratings of peer admiration (Becker & Luthar, 2007), with cigarette, alcohol, and marijuana use higher amongst those who believed that they received peer support for their substance use (Duan, Chou, Andreeva, & Pentz, 2009). Furthermore, Odgers, Houghton, and Douglas (1996) found that once this reputation was achieved, adolescents attempted to maintain it by continuing to engage in such behaviour.

Addressing Socially Motivated Adolescent Addictive Behaviours

It has been argued that policy makers have not responded adequately to the knowledge that these socially-motivated behaviours can have a large and sustained negative impact on adolescents' present and future wellbeing (Sawyer et al., 2012). This is particularly problematic given that the current population of adolescents is the largest in history, comprising more than a quarter of the world's population (Sawyer et al., 2012).

However, it is promising that researchers who are interested in adolescent health and health behaviours are increasingly calling for professionals and policymakers to adopt a social approach towards such issues. In particular, a recent series of papers published in The Lancet (Sawyer et al., 2012; Viner, 2012; Catalano, 2012; Patton et al., 2012) drew attention to the health-related plight of adolescents, along with the importance of seeking to improve adult health through the use of the life-course theory, which focuses on how our childhood and adolescent experiences impact upon

our adult health and wellbeing. Ultimately, the authors' recommendation was that the wellbeing of adolescents should be considered from a primarily social perspective.

This viewpoint echoes recent developments within the world health agenda (e.g. The Lancet, 2009) which suggest that traditional definitions of health and wellbeing need to be reconceptualised. Within our own country, Scotland's then-Chief Medical Officer, Sir Harry Burns, claimed in 2014 that traditional definitions of such terms fail to consider "the close and complex interrelationships between an individual's societal and environmental circumstances and their sense of wellbeing" (Burns, 2012, p. 4). In response, Burns referred to definitions of health that are firmly couched in social terms, such as an "ability to perform personally valued family, work and community roles" and an "ability to deal with physical, biologic, psychological and social stress" (Burns, 2012, p. 4). This definitional shift reflects a growing awareness amongst healthcare practitioners of the ways in which the social world and an individual's wellbeing are irrevocably entwined.

Such observations have encouraged an increasing number of health professionals to adopt a Social Determinants of Health (SDH) approach to adolescent wellbeing, which the World Health Organization defines as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (WHO, 2015). The SDH consist of both structural and proximal determinants, both of which impact upon individuals' health (Viner et al., 2012). Structural determinants include national wealth, income and sex inequality, access to education and health care services, as well as employment opportunities. In the case of adolescents, proximal determinants refer to factors such as connectedness

to family and school (Viner et al., 2012), and outcomes relating to the individual, their family, peers, and teachers are particularly important in relation to mental wellbeing and health behaviour. Consequently, it has been suggested that improving adolescent health requires an assessment of the nature of young people's interactions with their family, friends, peers, and teachers (Viner et al., 2012).

There are certain aspects of adolescents' relationships with these social groups that are particularly important for health behaviour. Elements that determine the quality of such relationships (e.g., having a sense of connectedness, good communication, support, involvement, and belonging within the group) can help protect against risky health behaviours and mental health problems. The family is one of the most important groups from this perspective, with adolescents who report high levels of family connectedness reporting lower levels of cigarette, alcohol, and marijuana use (Resnick et al., 1997). Smoking (Wang, Fitzhugh, Westerfield, & Eddy, 1995) and alcohol use (Bonnie & O'Connell, 2004) can be discouraged through healthy family norms and attitudes, as well as through healthy behaviour modeling. However, the nature of this influence depends entirely on the content of the norms, values, and behaviours in question: children of parents who smoke (Bauman, Carver, & Gleiter, 2001) and drink (Bonnie & O'Connell, 2004) are more likely to engage in these behaviours themselves.

The emotional component of group memberships is also important: in countries with greater family connections (versus countries with fewer family connections), adolescents were found to have fewer behavioural and mental health problems (Viner et al., 2012). They were also more likely to delay sexual initiation, and tended to

report lower levels of cigarette, alcohol, and marijuana use (Resnick et al., 1997).

Quality of relationships with others at school can also influence wellbeing, but this is dependent on the degree to which young people feel a sense of connection with peers, friends, and teachers (Osterman, 2000). Strong emotional connections between students and teachers can lead to reductions in substance misuse, violence, and other antisocial behaviours (Patton et al., 2006).

Finally, peers are able to influence behaviour in either positive or negative ways. As with the family, healthy peer norms and values can protect against substance misuse (Donovan, 2004), and strong peer connections can reduce the risk of adolescents engaging in a wide range of risky health behaviours (Anteghini, Fonseca, Ireland, & Blum, 2001; Resnick et al., 1997). However, as mentioned previously, adolescents' heightened sensitivity to peers can actually encourage their experimentation with addictive and risky behaviours, such as substance misuse (Patton et al., 2004; Trucco, Colder & Wieczorek, 2011), smoking, and alcohol initiation and persistence (Beal, Ausiello, & Perrin, 2001; Donovan, 2004; Kaplan, Nápoles-Springer, Stewart, & Pérez-Stable, 2001; Salazer, Santelli, Crosby, & DiClemente, 2009).

This knowledge regarding the crucial role that social groups can play in adolescent health behaviour reflects professionals' growing interest in the SDH approach. Moreover, the idea of improving public health through socially-framed interventions has received increasing amounts of interest from various governments and international agencies (Viner et al., 2012). This has been illustrated by numerous organisations commissioning national and international surveys in order to investigate

the social elements that can influence young people's health and behaviour. For example, the Health Behaviour in School Aged Children study (HBSC: World Health Organisation, Regional Office for Europe, 2012) is an international study spanning 43 countries that examines the health behaviours and contextual factors that are relevant to children aged 11-15 years. Across Scotland, several studies have also collected data on adolescent health, health behaviours, and social factors. For example, the Scottish Health Survey (Scottish Executive, 2005a), and the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS: NHS Scotland, 2005) focus on themes such as mental health, substance use, and contextual factors (e.g., schools, general environment, family and friendships).

Indeed, recent Scottish Government policies have made young people's health a key priority. The *Getting It Right for Every Child* (GIRFEC: Scottish Executive, 2005b) Programme, launched in 2006, provides the supporting methodology for all Scottish Government policies concerning children. National and local targets for children and adolescents have focused on obesity, mental health, and sexual health, as well as smoking, alcohol, and drug use. This holistic approach speaks to the fact that getting to the root of individual risky health behaviours can be difficult, since there are complex relationships between them, and they rarely occur in isolation (Parkinson, 2012).

However, despite these promising developments, there are still some problems with the SDH approach. Although researchers have proposed various models explaining how social determinants impact upon health and health behaviour, the literature contains inconsistent and competing models which use a variety of complex concepts

and terms (Viner et al., 2012). While experts within other disciples (e.g., anthropology, quantitative sociology, and epidemiology; c.f. Berkman, Glass, Brissette, & Seeman, 2000) have also found consistent links between social factors and wellbeing, such individuals have encountered similar problems regarding inconsistencies in how concepts are defined and measured. It is argued that this inconsistency can influence theorizing, study design, and data interpretation, ultimately leading to confusion regarding how to conceptualise and measure key concepts such as social connectedness (Jetten, Haslam, Haslam, Dingle, & Jones, 2014). In time, this confusion can promote methodological weakness and a lack of theoretical clarity.

Ultimately, the SDH approach can best be thought of as a starting point from which to address adolescent health behaviours. In particular, insights can be drawn from the proximal determinants of health, and how these social groups have the potential to influence adolescent behaviour. However, it is possible that an alternative yet complementary approach - the social identity approach – can offer a coherent and consistent perspective from which to draw insights regarding the prevention and treatment of adolescent addictive behaviours.

The Social Identity Perspective

The social identity approach (Turner et al., 1987) is founded on the idea that as well as having a personal identity, one also possesses multiple social identities, which are obtained through membership of social groups. In certain contexts, specific social identities will become salient (or prominent), meaning that (for instance), one might think of oneself as a woman in one context, or as a psychologist in another context.

Crucially, these salient social identities effect cognitions and behaviour, as we attempt to think and act in ways that are consistent with the prevailing norms, values, and beliefs of our currently-salient social identity. Moreover, we will attempt to help, support, and co-operate with people whom we consider to be fellow in-group members (Haslam, 2004). In this way, our social world provides us with a complex and dynamic sense of who we are and how we relate to those around us at any particular moment.

It is important to note, however, that these effects will be stronger when we feel psychologically invested in the group in question: in situations where the group and its members matter to us, and are central to our lives (e.g., Oakes, Haslam, & Turner, 1994). This means that there is an important distinction between simply being a nominal member of a group and actually *identifying* as a group member.

This subjective sense of *group identification* is a central tenet of the social identity perspective, but it can also provide a new dimension to the SDH approach. The sense of shared social identity that group identification fosters provides the psychological foundation for positive, meaningful, and supportive social interactions (Cruwys, Haslam, Dingle, Haslam, & Jetten, 2014). Group identification thus has the ability to influence both thoughts and behaviours in positive ways.

The remainder of the chapter will outline evidence which supports the idea that the social identity perspective can provide a coherent and theoretically-based approach to adolescent addictive and risky behaviours, thereby remedying some of the SDH perspective's shortcomings. Identifying with particular social groups can influence

health behaviours, and there will be consideration of why such influence may occur. The future implications of this work will be investigated in relation to how group identification may influence the uptake and maintenance of various health behaviours, as well as how this knowledge could be used to improve adolescents' health.

Group Identification and Health Behaviours

Social identity processes can influence health behaviours in complex ways, partly due to the role played by group norms. Norm adherence can be used to strengthen in-group cohesion and validate one's status as a group member (Hogg & Abrams, 2003; Turner et al., 1987), an effect that may be especially relevant for adolescents, who are susceptible to peer influence and have a strong desire to 'belong' (e.g. Hogg et al., 2011). Moreover, group identification increases one's likelihood of acting in accordance with the norms of that particular group (e.g. Turner, 1991). While this is helpful in the context of healthy norms (e.g., exercise, or getting vaccinated), adherence to unhealthy norms (e.g., smoking or binge drinking) can be harmful. This helps to explain why the health-related behaviours encouraged by group identification are not always positive.

Thus when a behaviour is seen as something 'we do' (i.e., normative), group members can be motivated to perform that behaviour because of its identity consequences. For example, Oyserman, Fryberg, and Yoder (2007) found that White middle-class participants were likely to associate health-promoting behaviours with their ingroup, while ethnic minority participants were more likely to associate health-harming behaviours with their ingroup. As a result, the ethnic minority participants were more likely to report negative attitudes towards health when their social identity was made salient, leading to reduced cognitive accessibility of health-related

knowledge, more health fatalism, and weaker perceptions of the importance of engaging in healthy behaviours.

These findings were supported by a qualitative study by Stewart-Knox and colleagues (2005), who examined why adolescents start smoking. They found that smoking was used as a means by which to define group membership and differentiate between different groups. In a series of interviews with young people spanning 3 years, they found that rather than peers influencing smoking uptake through direct persuasion, peer influence occurred indirectly when young people tried to conform to the normative behaviour of the peer group with which they identified. The authors suggested that smoking was not a reason for group affiliation, but was rather a behaviour that signified one's membership of the group: both smoking and not smoking were used strategically as a means to accentuate similarities within the in-group and differences between the in-group and out-groups.

However, it is important to remember that these behaviours will only be found amongst those who identify highly with the group in question. Such individuals will tend to be strongly influenced by group norms, whereas those who identify to a lesser extent will be less likely to be influenced. There is thus an interaction between group norms and group identification, with identification moderating the extent to which group norms influence behaviour (see Figure 5.1).

<FIGURE 5.1 HERE>

This relationship has been illustrated with a variety of health behaviours. For example, Schofield and colleagues (2001, 2003) found that group identification

increased conformity to peer group norms, and this led to increased smoking behaviour amongst adolescents who identified highly with a peer group that was associated with extensive smoking. Similarly, Åstrøm and Rise (2001) found that group identification moderated the extent to which young people planned to eat healthily: those who identified highly were more likely to eat healthily (in accordance with the group norm) than those who did not identify strongly with the group. These results have been replicated with a number of other health behaviours, including exercise, sun-protective behaviour (Rivis & Sheeran, 2003; Terry & Hogg, 1996), and binge drinking (Johnston & White, 2003).

These studies illustrate that group identification can be a double-edged sword: although group identification is associated with many positive health outcomes, it also increases adherence to group norms, which can on occasion be negative. However, knowledge of these processes can be used to improve health behaviour. This can be achieved by altering the salience of different identities to encourage healthy normative behaviours. For example, Tarrant and Butler (2011) found that when an 'unhealthy identity' (student) was salient, participants were less likely to engage in healthy behaviours than when a 'healthier identity' (nationality) was salient. Similar outcomes for smoking were found when a family identity (vs. a peer-group identity) was made salient (Kobus, 2003; Schofield et al., 2003), while making a 'family man identity' salient (vs. a 'miners' masculine identity') has been shown to lead to safer sex behaviour (Campbell, 1997).

This knowledge is increasingly being used in treatment settings. For example, in a study with former substance users, Buckingham, Frings, and Albery (2013) revealed

that possessing an 'addict identity' influenced subsequent substance use. However, more negative feelings towards the addict identity were associated with reduced substance use and lower rates of relapse amongst both former smokers and those who attended Alcoholics Anonymous/Narcotics Anonymous meetings. Similar results have been noted in an adolescent population with Kelly, Stout, Greene, and Slaymaker (2014) investigating how social networks can influence young people's recovery from substance use disorder (SUD). They found that a 12-Step Treatment Programme encouraged social network change, with 'high-risk' friendships having decreased and 'low-risk' friendships having increased at follow-up. Kelly and colleagues used these results to highlight the importance of social networks when treating young people with SUDs.

Dingle, Stark, Cruwys, and Best (2014) expanded upon these ideas by suggesting that relinquishing an addict identity would allow individuals to identify with a 'recovery identity'. They found that amongst those recovering from drug and/or alcohol abuse, treatment outcomes and wellbeing were influenced by identification with the therapeutic community (TC). Over the course of a treatment programme, identification with the TC increased. In contrast, participants' social identity as members of substance-using social groups was lower after entry to the TC and decreased throughout the programme, with substance-using identities and recovery identities increasingly diverging over time. Dingle and colleagues (2014) concluded that identity transition is an important step in recovery from alcohol and drug misuse. Those who continued to identify with their substance-using peers at follow-up experienced much poorer outcomes in terms of substance use and life satisfaction. In

contrast, those who retained their recovery identity showed positive outcomes in terms of substance abstinence and life satisfaction.

Furthermore, when considering group norms, Cruwys, Haslam, Fox, and McMahon (2015) found that in a group intervention for disordered eating, normative change was able to influence both eating-related cognitions and eating intentions over time. One of the particularly noteworthy aspects of this intervention was that participants were encouraged to challenge previously-accepted norms by means of a group discussion. This very quickly allowed the norms of the peer group to change from promoting unhealthy eating to promoting healthy eating. These insights could be used in group settings with addicts, or those at risk of participating in addictive behaviours. Indeed, Cruwys and colleagues (2015) suggest that such mechanisms of normative change could be used with a variety of vulnerable people who are undergoing group therapy. In a study of recovering addicts, the authors found that normative change accounted for up to 26% of patient improvement (Cruwys et al., 2015), thereby illustrating the substantial impact that social factors can have on an individual's behaviour.

This work is promising to the extent that it illustrates how identity processes can be used to change detrimental behaviour in both every-day and therapeutic settings. In recent years, such findings have been extended by research highlighting the important health-related outcomes that can be obtained from identification with *multiple* groups, and how multiple group identifications can be used to protect against the development of risky behaviours.

Impact of multiple group identifications on health behaviour

As previously discussed, group identification can have different implications for health depending on the norms of the different groups involved, and this is particularly important when considering multiple group identifications. For example, Verkooijen, de Vries, and Nielsen (2007) found that identification with several 'high risk' groups (that had norms associated with substance use) was associated with higher risks of substance use, whereas identification with 'low risk' groups (which did not have norms associated with substance use) was associated with lower risks, with this relationship being influenced by the nature of the perceived group norms. However, the most important aspect of their findings was that identifying with multiple groups with competing norms actually led to a weaker relationship between group norms and behaviour in general, thereby 'diluting' the behavioural impact of negative norms.

This research is consistent with recent work by Sani and colleagues (2015), who found that that the more group identifications participants had, the less likely they were to participate in risky health behaviours (smoking and drinking heavily), and the more likely they were to have a good diet and to engage in physical exercise. The authors' explanation for these findings was that having more groups with which one identifies strongly can over-ride any negative effects of identifying with groups with negative norms. This is partly because group identification can provide a variety of psychological benefits, including a greater sense of meaning and purpose in life, as well as feeling that one is likely to receive support from fellow group members in times of crisis. These in turn can promote positive affect, as well as providing an incentive (and a sense of obligation) to look after oneself so that one will be healthy enough to help the group achieve its aims and goals.

These conclusions were supported by Miller, Wakefield, and Sani (2016), who examined the relationship between identification with three different groups (family, school, and friends) and health behaviours in over 1000 secondary school pupils aged between 13 and 17. The authors found that the relationship between group identification and behaviour differed for the individual groups under study. Both family and school identification predicted reduced odds of smoking, binge drinking, and cannabis use. In contrast, friend identification predicted increased odds of smoking, binge drinking, and cannabis use. Furthermore, when the impact of multiple group identifications was considered, the results were consistent with those of Sani et al. (2015), showing that multiple group identifications predicted reduced smoking, binge drinking, and cannabis use.

These findings therefore support both Sani et al.'s (2015) and Verkooijen et al.'s (2007) conclusions that having multiple group identifications can 'cancel out' any negative behaviours associated with identifying with groups which possess unhealthy norms. When aiming to improve adolescents' health/risky behaviours, we should therefore encourage them to identify with as many groups as possible, thereby helping them to cultivate a social environment that protects them against unhealthy and addictive group norms.

Implications

When considering how to use these insights to help adolescents who engage in (or are at risk of engaging in) addictive behaviours, the suggestion is that professionals should encourage such individuals to identify with groups which possess healthy norms. This would have the benefit of increasing the likelihood of them engaging in

positive behaviour, and would also protect against identification with groups which possess unhealthy norms. In turn, this would allow adolescents to draw a sense of identity from positive, healthy groups, rather than substance-using groups, the latter of which would provide both a substance-using identity and the desire to behave in accordance with these damaging norms (e.g. Best et al., 2015).

The onus is therefore on those interested in adolescent wellbeing to provide groups which possess healthy norms with which young people would be able to identify. Hogg and colleagues (2011) suggest (citing Carroll, Houghton, Durkin, & Hattie, 2009; Mosbach & Leventhal, 1988) that adolescents should be encouraged to identify with groups beyond the confines of immediate peers and other adolescents. In particular, they recommend groups which would enable adolescents to adopt adult responsibilities – perhaps grounded in the local community or organisations that would provide a distinctive, strong, and valuable sense of self. Such groups have the potential to protect young people against the uncertainty of adolescence, while still enabling them to garner respect from relevant others.

Furthermore, young people should be encouraged to identify with as many of these groups as possible. As outlined above, identifying with many groups can increase the likelihood of engaging with groups which possess healthy norms. While identification with several groups with healthy norms would be the ideal situation, and indeed, should be the aim, the most promising aspect of this work is that multiple group identifications have the ability to compensate for identification with groups with any unhealthy norms. This means that having these multiple group identifications can

provide a useful 'safety net' to protect even those who identify with groups which encourage unhealthy behaviours.

Conclusion

The central importance of adolescent wellbeing to overall public health is gradually being accepted by healthcare practitioners, government bodies, international agencies, and researchers. There is growing awareness of the importance of addressing this group when considering ways to improve – and protect – population health. One of the most straightforward ways to do this is to prevent the development of risky health behaviours during adolescence. Doing so has long- and short-term benefits at both an individual and a societal level. For example, it will protect the health and wellbeing of the young people themselves, it will prevent the immediate and long-term social problems associated with substance use, and, finally, it will prevent these behaviours from becoming deeply-rooted addictions that continue into adulthood.

The social identity approach provides an integrated theoretical perspective which draws together and builds upon knowledge provided by other disciplines regarding health-related behaviour. The social identity approach, supported by a growing body of empirical research, allows consideration of the ways in which social factors can be used to aid recovery, protect against participation in unhealthy behaviours, and ultimately prevent these behaviours from occurring in the first place. Using a holistic approach, it is possible to utilise knowledge about social identities and group membership in order to address both psychological and behavioural outcomes, thus protecting all aspects of wellbeing. Doing this means that more resources are available to help prevent young people from becoming involved in risky health

behaviours that could eventually evolve into harmful addictions. Thus, even millennia on, there is still truth in Aristotle's observation that "good habits started in youth can make all the difference".

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